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WEB-BASED AUTOMATED RESPONSE SYSTEM (ARS) USER GUIDE

Issued April 2005

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GENERAL INFORMATION

The Automated Response System (ARS) User Guide is a joint publication by the Department of Medical Assistance Services (DMAS) and the First Health Services Corporation (FHSC). ARS provides twenty-four-hour-a-day, seven-day-a-week internet access to eligibility information, service limits, claim status, prior authorizations, provider check status and prescribing provider ID lookup (for pharmacy providers only). This web-enabled tool will help provide cost-effective care and allow quick, convenient access to information. Unlike MediCall (the voice response system), there are no limits to the number of inquiries per session. Finally, this system has been redesigned and is HIPAA compliant.

 **NOTE:** A new Automated Response System (ARS) Web Site was implemented on 02/19/07. Many new features can be found on the Web Site including improved access to business information needed by Medicaid providers as well as the User Administration Console (UAC). The UAC will allow you, the provider, to manage your own ARS access to one or more users. The UAC is an application that allows the provider to assign a Delegated Administrator for its office or facility.

Once the new NPI compliant ARS system is functional you can access information using your Medicaid ID, NPI, or API. All providers must transition to the new ARS system by May 22, 2007.

SCOPE

This manual provides basic instructions and screen prints for the registration, log-on and use of ARS. It provides detailed explanations of both the request and response screens for each function of ARS. The glossary and appendix provide supplemental information to aid in the interpretation of ARS data. This manual functions as a user guide, not as a technical document that explains how the computer system is designed and operates.

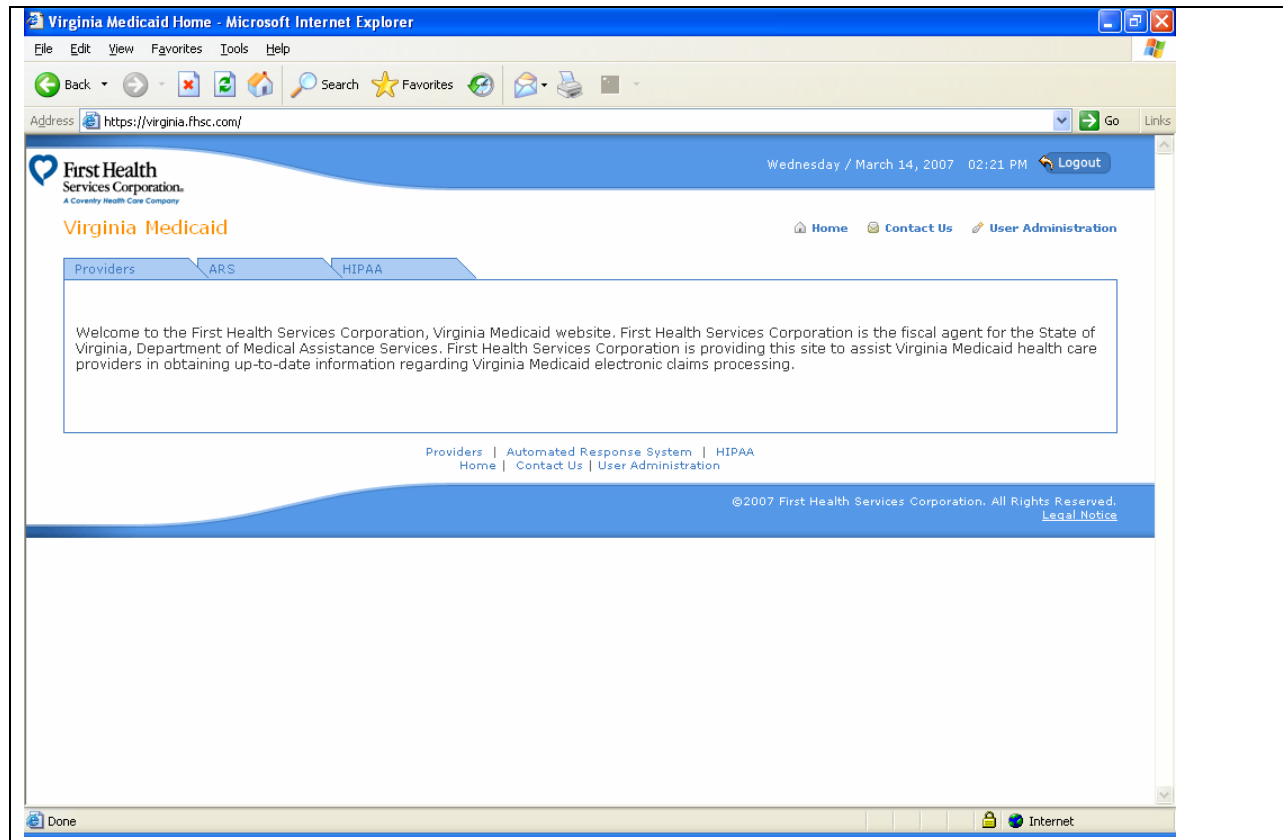
GETTING STARTED

The ARS system can be used by anyone with an internet-connected PC, web browser and an active Medicaid provider number. The provider number is required as part of the log-on process. After going to the Virginia Medicaid web site at <http://virginia.fhsc.com>, move the cursor over the box that says “Automated Response System (ARS)” in a few seconds an additional menu will display. This menu offers four options. First time users need to select “Secure Registration.” If you are not a first time user, select “User Administration.” Selecting “ARS Users Guide” will link you with a copy of this manual. The “FAQ” (Frequently Asked

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Questions) section answers general questions about ARS. FAQs are also available in this manual.

Below is a picture of the <http://virginia.fhsc.com> home page:



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Secure Registration (First Time Users)

A new user must first register to use ARS. After selecting “User Administration”, select the “Register for ARS via UAC” button and select the “Submit” button.

Virginia Medicaid ARS Registration Decision Page - Microsoft Internet Explorer

Address: <https://virginia.fhsc.com/Providers/decideRegistration.asp>

Thursday / March 15, 2007 10:29 AM Logout

First Health Services Corporation
A Coventry Health Care Company

Virginia Medicaid

Home Contact Us User Administration

Providers ARS HIPAA

ARS Registration

- Select "ARS via Legacy Registration", if you need immediate access to ARS.
- Select "ARS via the UAC", if you would like to begin setting up your future access to ARS with Delegated Admin controls.

☐ Register for ARS via Legacy Registration.

**** IMPORTANT -- IF YOU CHOOSE TO REGISTER WITH LEGACY REGISTRATION, YOU WILL STILL NEED TO RE-REGISTER USING THE UAC PRIOR TO 05/23/2007 IN ORDER TO CONTINUE USING ARS. ****

***** IMPORTANT -- NEW USERS WHO CHOOSE TO REGISTER WITH LEGACY REGISTRATION FOR IMMEDIATE ACCESS, WE RECOMMEND THAT YOU ALSO REGISTER WITH THE UAC IN ORDER TO AVOID ANY INTERRUPTIONS IN ACCESS TO ARS ON OR AFTER 05/23/2007. *****

☒ Register for ARS via the UAC (recommended).

**** IMPORTANT -- IF YOU CHOOSE TO REGISTER USING THE UAC, THE ACCOUNTS CREATED IN THE UAC WILL NOT HAVE ACCESS TO ARS UNTIL 03/26/2007. ****

Submit

Providers | Automated Response System | HIPAA
Home | Contact Us | User Administration

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Select the “I do not have a user ID and need to be a Delegated Administrator” button and select “Continue”.

FHSC UAC v2.0 - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Print

Address <https://uac.fhsc.com/uac/pages/unsecured/common/home.jsf> Go Links

Thursday / Mar 15, 2007 3:44 PM Help

First Health Services Corporation
A Coventry Health Care Company

UAC User Administration Console

User Administration Console v2.0

Who are you? [?](#)

PLEASE INDICATE YOUR STATUS AND CLICK CONTINUE.

- ☐ I am an Administrator and need to perform User administration work.
- ☐ I have a User ID and need to be upgraded to a Delegated Administrator.
- ☒ I do NOT have a User ID and need to be a Delegated Administrator.

[Continue](#)

SCREEN ID: home

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Done Internet

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The steps are listed for requesting a PIN number to be able to register for access to the ARS system.



Secure Logon (Registered Users)

Registered users will enter their logon information from the “Automated Response System (ARS)” menu to begin an inquiry.

To logon, enter the 9-digit Medicaid provider number with the prefix “VA,” for example VA999999999. For 7-digit provider numbers, enter the prefix VA00 -- VA009999999. Next, enter your password. Passwords are case sensitive; Therefore, if you initially register your password in all capital letters, you must continue to type it in capitals each time you log on.

ARS Logon Failure

If the logon fails, the following error message appears:

“Logon failed
Please try again”

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Try the logon again. If the logon continues to fail, call the Web Support Unit for First Health Services Corporation at the telephone number listed below:

1-800-241-8726 All local and long distance calls

ARS Access Problems

The following message appears when there is a problem processing the session:

“Your interactive session cannot be processed at this time.”

Possible Causes

In most cases you receive this message because all software agents are currently busy. Other possible causes of the problem include

- Resources needed by the application could not be acquired at the time.
- The application you are trying to access is not running.
- The application you are trying to access has been changed.

Resolution

1. Reload the previous page and try again.
2. Try this application at a later time:
 - The best time to access ARS is in the morning before 10 A.M. and in the afternoon after 2 P.M. Mondays and Fridays are also better days to access ARS.

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Below is a picture of the secure logon screen:

Virginia Medicaid Secure Login - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Internet Options

Address <https://vaedify.fhsc.com/ICSLogin/?https://vaedify.fhsc.com/> Go Links

First Health Services Corporation
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Virginia Department of Medical Assistance Services (DMAS) Eligibility and Provider Payment Verification Secure Login

Welcome. To help you provide quality patient care with minimum cost, DMAS makes available enrollee eligibility and claim status. Please enter your provider number. Seven digit numbers should be preceded by two zeroes. Press the tab key, and type in the password previously given to you by the Provider Unit. When finished, please use your mouse to click on the Submit button or press Enter.

User Id:

Password:

Please log In

Forgot Your Password? [Click Here!](#)

Need to Change Your Password? [Click Here!](#)

The use of this page is for treatment, payment, and operations for providers, clearinghouses or business partners with contracts with DMAS or its Fiscal Agent, First Health Services Corporation. If you do not meet this criterion, please exit this page now.

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Internet

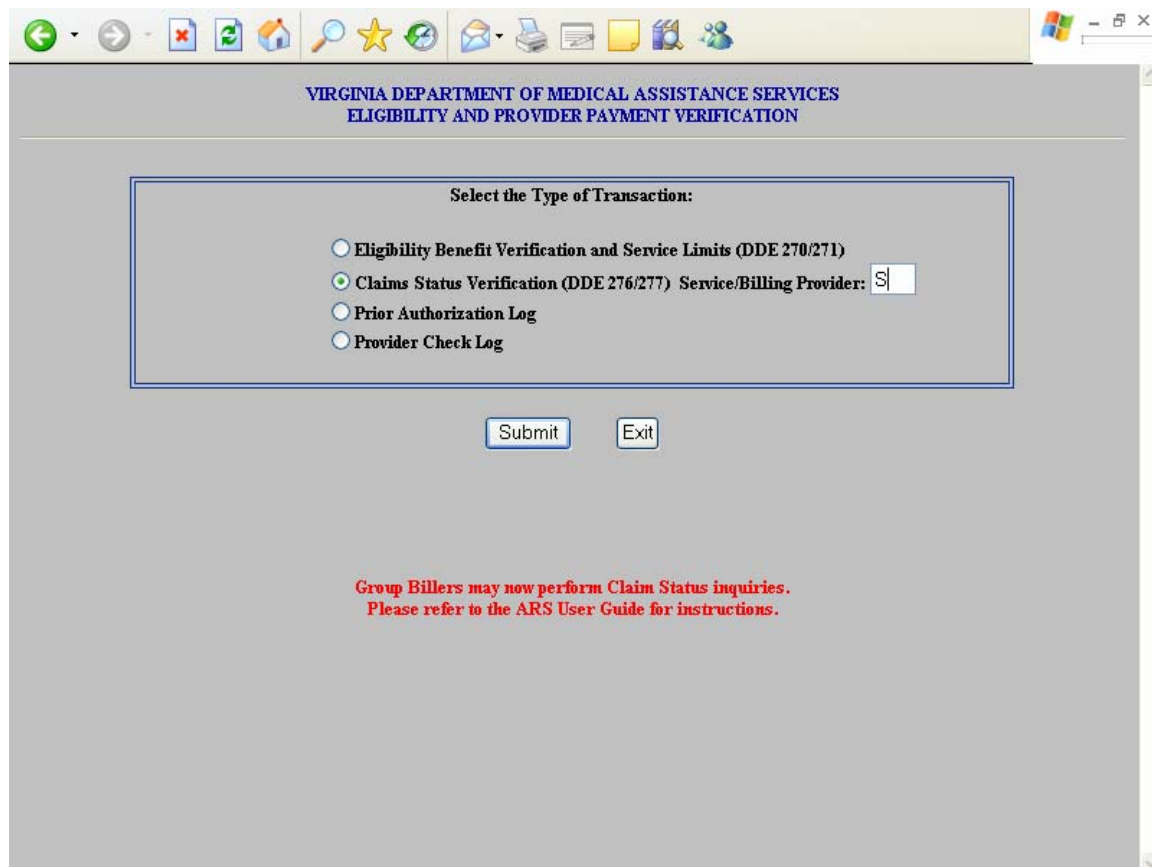
NOTE: For security purposes, passwords must be changed every 45 days.

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USING ARS

Main Menu Screen

After logging on, the main menu screen appears. Depending on the type of provider, there will be either four or five choices. Below is a picture of the main menu screen:




VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
ELIGIBILITY AND PROVIDER PAYMENT VERIFICATION


Select the Type of Transaction:

☐ Eligibility Benefit Verification and Service Limits (DDE 270/271)
☒ Claims Status Verification (DDE 276/277) Service/Billing Provider: S
☐ Prior Authorization Log
☐ Provider Check Log

Submit Exit

Group Billers may now perform Claim Status inquiries.
Please refer to the ARS User Guide for instructions.

 **NOTE:** Only pharmacy providers have access to the Prescribing Provider ID lookup option. This option will only appear on the menu for those providers with a pharmacy provider ID.

 **NOTE:** If selecting 'Claims Status Verification' the user must enter 'S' for Servicing Provider or a 'B' for Billing Provider in the white box.

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Make a selection and click “Submit.” A screen corresponding to that specific transaction will appear.

Selecting “Exit” on this screen will take you out of ARS.

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1. Eligibility Benefit Verification and Services Limits

The next two screens are used to verify eligibility and service limits for a patient. The first screen will prompt you to provide enrollee identification information. The second screen returns eligibility and service limits data pertaining to the enrollee identified in the query.

1a. Request Screen

When this option is selected from the main menu, you will be prompted for the following information:

- Enter the enrollee number (ID code) assigned by DMAS; OR
- Enter any two of the following:
 - Enrollee social security number (without dashes)
 - Enrollee date of birth (The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third field holds a four-digit number for the year (CCYY))
 - Enrollee name (Middle initial is optional)

Regardless of which type(s) of enrollee identification you provide, you must include the service dates. Service dates cannot span more than one month. If the service date is only one day, enter the same day in both fields. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY). The service “from” date must be within one year from the current date. Future service dates are not allowed.

Enter the provider’s control or trace number. This is a tracking control number for internal purposes only. You are required to enter a value in this field. It can be a patient account number, a date and time, or any other alpha/numeric code chosen by the provider to track this inquiry. This field will accept up to 30 characters.

To receive service limit information, the service limit type must be selected from the “Service Type Code” drop down box. This is not a required field. It is to be used only by providers that fall into one of the following categories:

- 42 – Home Health Care (Home Health Aide)
- 43 – Home Health Visits (Skilled Nursing)
- AD– Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy



NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

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The Constant Reference Designators and Description drop down menu displays the constant elements defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are required in standard X12 transactions. They are not required to access the eligibility and provider verification system and should be ignored.

Press “Submit Query” after entering the data. If any information entered is incorrect, a red error message will be displayed at the top of the form. Type in the correct information and resubmit. The HIPAA 270/271 Implementation Guide including the “Service Type Codes” can be obtained free of charge at <http://www.wpc-edi.com/products/publications>. The enrollee CoPay Indicator (Special Indicator Code – Copayment Code) definitions are found in Chapter III of your Medicaid Provider Manual. Please note that the new Program Benefit Name “FAMIS Plus” refers to certain children with **Medicaid** coverage.

Selecting “Exit” on this screen will take you out of ARS.

Below is a picture of the eligibility screen:

The screenshot shows a web browser window titled "Query Elig and Serv Psych DDE 270 - Microsoft Internet Explorer". The address bar shows the URL: https://vaedify.fhsc.com/scripts/cgicnt.exe/VWOMJ688MMY1U4FVCVRACY3KQ/ND001__. The page content is titled "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES ELIGIBILITY BENEFIT VERIFICATION AND SERVICE LIMITS (DDE 270)".

The form contains the following fields and sections:

- Provider ID:
- Entity Type Qual: 2
- Enter the Enrollee Number (ID Code):
- Service Dates From/To (Date Time Period): -
- If the Enrollee Number (ID Code) is not known, enter two of the following: SSN, Birth Date and Name
- Enrollee SSN (Ref ID):
- Enrollee (Subscriber Birth Date):
- Last Name:
- First Name:
- MI:
- Provider's Control Number:
- For Service Limits enter Service Type Code:
- Originating Company Number:
- Constant Reference Designators and Descriptions:

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1b. Response Section

Below is a picture of the eligibility verification and service limits response screen:

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
ELIGIBILITY VERIFICATION

Requesting Provider: 00490 Requested Enrollee: 001008
 SSN: 230-50- Birthdate: 10/16/19 Name:
 Verification Number: 08161-0000002

Eligibility Information
 Current aid category: 011 07/20/2001 - 09/30/2001
 Latest MCO: HEALTHKEEPERS PLUS, PENINSULA Previous MCO: SENTARA FAMILY CARE
 CARE

Benefit Plan	Exc Ind	Begin	End	Patient Pay	Provider	Provider Phone
MEDICAID FFS		07/20/2001	09/30/2001	0.00	000000000	000-000-0000
XIX TIDEWTR		08/01/2001	09/30/2001	0.00	004700	000-000-0000
XIX CENTRAL		07/20/2001	07/31/2001	0.00	004700	000-000-0000

TPL Information

Carrier Code	Coverage Type	Begin	End	Copay	Deductible

Menu Exit

NOTE: Insurance codes, listed in alphabetical and numeric order, are available at <http://www.dmas.state.va.us/pr-home.htm>

Selecting “Exit” on this screen will take you out of ARS.

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2. Claims Status Verification

The next two screens are used to check on the status of a claim. The first screen will prompt you to provide information regarding a claim. The second screen returns claims status data pertaining to the claim identified in the query.

2a. Request Screen

When this option is selected from the main menu, you will be prompted for the following information:

- Enter the Payor's Claim Control Number (ICN); OR
- Enter the enrollee number assigned by DMAS and the service dates:
 - Service dates cannot span more than one month. If the service date is only one day, enter the same day in both fields. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY). The service "from" date must be within one year from the current date. Future service dates are not allowed.

You may also enter the billing provider ID number. If the billing provider's ID number is not provided, the search will default to the provider number.

Enter the provider's control or trace number. This is a tracking control number for internal purposes only. You are required to enter a value in this field. It can be a patient account number, a date and time, or any other alpha/numeric code chosen by the provider to track this inquiry. This field will accept up to 30 characters.

The Constant Reference Designators and Description drop down menu displays the constant elements defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are required in standard X12 transactions. They are not required to access the eligibility and provider verification system and should be ignored.

The HIPAA 276/277 Implementation Guide can be obtained free of charge at <http://www.wpc-edi.com/products/publications>. The "Health Care Claim Status Category Codes and the Health Care Claim Status Codes" can also be obtained free of charge at <http://www.wpc-edi.com/products/codelists/alertservice>.



NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

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Press “Submit Query” after entering the data. If any information entered is incorrect, a red error message will be displayed at the top of the form. Type in the correct information and resubmit.

Selecting “Exit” on this screen will take you out of ARS.

Below is a picture of the claims status request screen:

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLAIMS STATUS VERIFICATION (DDE 276)**

Entered Provider ID Number: 004 Entity Type Qual:

Enter ICN (Payor's Claim Control Number):

If ICN is not known, enter Enrollee Number and Service Dates OR Enrollee Number, Service Dates and Servicing Provider

Enrollee Number (ID Code):

Service Dates From/To (Date Time Period): -

Billing Provider:

Provider's Control Number (Ref ID):

Constant Reference Designators and Descriptions

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2b. Response Section

A claim search can return more than one claim. If this occurs, each claim will be displayed in a different claim level box. The same is true for line items; each line item will be displayed in a different status box. Below is a picture of the claims status verification response screen:

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLAIMS STATUS VERIFICATION (DDE 277)

Provider (Servicing)
 Provider ID: 0049812
 Last Name: MEDICAL First Name: LAB MI: Suffix:

Information Receiver
 ID Number: 0049812
 Last Name: MEDICAL First Name: LAB MI: Suffix:

Enrollee Information
 Enrollee Number (ID Code): 013-069
 Last Name: First Name: MI: Suffix:
 Subscriber Birth Date: 09/29/19 Gender Code: M
 RefID (Provider Control Number): 12345

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Response Section Cont'd

Claim Status DOE 277 Header - Microsoft Internet Explorer

File Edit View Favorites Tools Help

ICN (Payer Claim Control Number): 200327380039

Dates of Service From/To (Date Time Period): 09/25/2003-09/25/2003

Medical Record ID Number:

Bill Type ID:

Payment Method Code: CHK

Check Number: 000147

Total Claim Charge Amt: 46.65

Adjudication or Payment Date: 10/10/2003

Claim Payment Amount: 11.29

Status Information Effective Date: 10/03/2003

Health Care Claim Status

(Cat Code)	(Code)
(1) F1	65
(2)	
(3)	

Line Level Status

Proc Code (Service ID Code)	Procedure Modifiers (1) (2) (3) (4)	Line Item Charge Amt	Line Item Provider Payment Amt	Revenue Code	Units (Quantity)	Health Care Claim Status Cat Code (1) Code (1)	Health Care Claim Status Cat Code (2) Code (2)
80076		46.65	11.29		1	F1 65	

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Response Section Cont'd

Claim Status CDE 277 Header - Microsoft Internet Explorer

File Edit View Favorites Tools Help

ICN (Payer Claim Control Number): 200327380039
 Dates of Service From/To (Date Time Period): 09/25/2003-09/25/2003
 Medical Record ID Number:
 Btl Type ID:
 Payment Method Code: CHK
 Check Number: 000147
 Total Claim Charge Amt: 50.90
 Adjudication or Payment Date: 10/10/2003
 Claim Payment Amount: 18.72
 Status Information Effective Date: 10/03/2003

Health Care Claim Status
 (Cat Code) (Code)
 (1) F1 65
 (2)
 (3)

Line Level Status

Proc Code (Service ID Code)	Procedure Modifiers				Line Item Charge Amt	Line Item Provider Payment Amt	Revenue Code	Units (Quantity)	Health Care Claim Status		Health Care Claim Status		
	(1)	(2)	(3)	(4)					Cat Code (1)	Code (1)	Cat Code (2)	Code (2)	
80164					50.90	18.72		1	F1		65		

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3. Prior Authorization Log

The Prior Authorization (PA) Log displays the requests for PA that a provider has submitted. The next two screens are used for PA requests. The first screen will prompt you to provide enrollee identification information. The second screen returns PA data pertaining to the enrollee identified in the query.

3a. Request Section

When this option is selected from the main menu, you will be prompted for the following information:

- Enter the Enrollee Number (ID Code) and the service dates:
 - Service dates cannot span more than one month. If the service date is only one day, enter the same day in both fields. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY). The service “from” date must be within one year from the current date. Future service dates are not allowed.

OR

- Enter any two of the following:
 - Enrollee social security number (without dashes)
 - Enrollee date of birth (The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third field holds a four-digit number for the year (CCYY))
 - Enrollee name (Middle initial is optional)
 - Prior authorization number assigned by DMAS
 - Procedure code (Standard HIPAA codes, up to seven characters)



NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

Press “Submit Query” after entering the data. If any information entered is incorrect, a red error message will be displayed at the top of the form. Type in the correct information and resubmit.

Selecting “Exit” on this screen will take you out of ARS.

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Below is a picture of the prior authorization log request screen:

The screenshot shows a web browser window titled "Query Prior Authorization Log - Microsoft Internet Explorer". The address bar displays the URL: https://vaedify.fhsc.com/scripts/cgicnt.exe/BVHQX9@NBAE2Q@2V335VC8Y/ND001_. The main content area has a title "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES PRIOR AUTHORIZATION LOG". Below the title is a form with the following fields and labels:

- Enter the Enrollee Number (ID Code):** [Text Input Field]
- Service Dates From/To (Date Time Period):** [Month] [Day] [Year] [Month] [Day] [Year]
- If the Enrollee Number (ID Code) is not known, enter two of the following:**
- Enrollee SSN (Ref ID):** [Text Input Field]
- Enrollee (Subscriber Birth Date):** [Month] [Day] [Year]
- Subscriber Name (Last, First, MI):** [Text Input Field] [Text Input Field] [Text Input Field]
- PA Log - Enter Prior Authorization Number:** [Text Input Field] **or Procedure Code:** [Text Input Field]

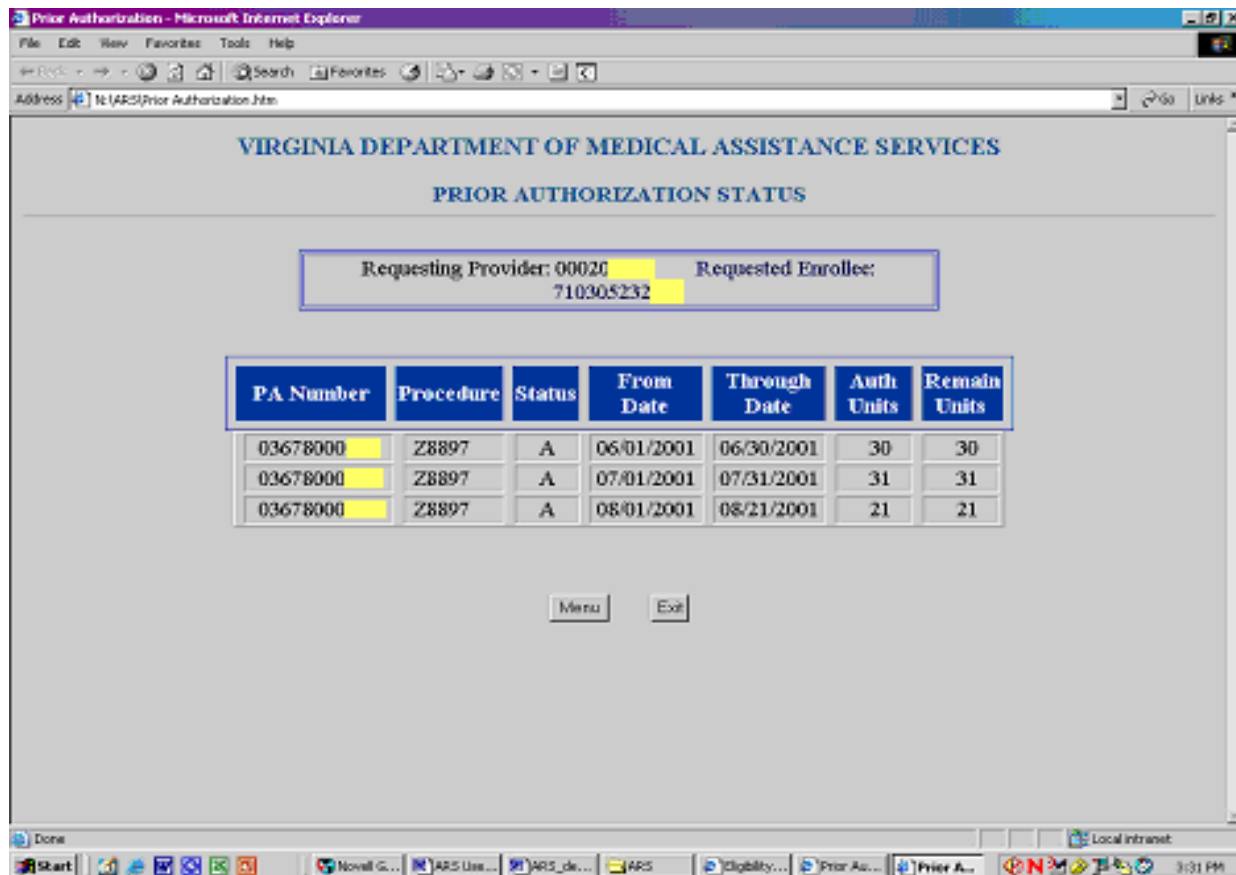
At the bottom of the form are two buttons: "Submit Query" and "Exit". The Windows taskbar at the bottom shows the Start button, several application icons, and the system clock displaying 2:12 PM.

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3b. Response Section

A prior authorization (PA) log search can return more than one PA. If this occurs, all of the PAs on record will be displayed.

Below is a picture of the prior authorization status response screen:



Prior Authorization Status Codes:

The following codes are used in the ARS system to indicate the status of prior authorization:

- A - Approved
- J - Reject
- D - Denial
- R - Request received at First Health Services (Please do not mail outpatient psychiatric services requests to FHS. The requests should be faxed to DMAS: (804) 225-2603 or (866) 248-8796
- P - Pending

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4. Provider Check Log

The Provider Check Log shows the check reimbursements made to the provider. The next two screens are used for check log requests. The first screen will prompt you to provide remittance information. The second screen returns all transactions pertaining to the given date.

4a. Request Section

To request the check log, the provider must enter the remittance date. The first two fields hold a two-digit number for the month (MM) and day (DD), respectively. The third service date field holds a four-digit number for the year (CCYY).



NOTE: For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

Press “Submit Query” after entering the data. If the date is entered incorrectly, a red error message will be displayed at the top of the form. Type in the corrected date and resubmit.

Selecting “Exit” on this screen will take you out of ARS.

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Below is a picture of the provider check log request screen:

The screenshot shows a web browser window titled "Query Check Payment - Microsoft Internet Explorer". The address bar displays the URL: https://vaedify.fhsc.com/scripts/cgicnt.exe/VWGFxZW887E1QPWV35EAC6L/ND001_. The main content area has a light gray background with the following text and form elements:

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PROVIDER CHECK LOG**

Provider Check Log - Enter Remittance Date:

The browser's status bar at the bottom shows "Done" and a taskbar with several open applications, including "Novell Gro...", "ARS Provid...", "ARS User ...", "Query Ch...", and "Document1...". The system clock in the bottom right corner indicates the time is 2:18 PM.

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4b. Response Section

The provider checklog displays all transactions for the given date. Below is a picture of the check payment response screen:


VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CHECK PAYMENT STATUS

Requesting Provider: 00490

Transaction Type	Check/Transfer Number	Payment Amount	Remittance Date
I	000154	38.30	03/23/2001
I	000646	1,867.11	03/16/2001
I	000630	26,445.55	03/09/2001
I	000616	28,268.00	03/02/2001
I	000600	11,315.39	02/23/2001
I	000585	21,995.01	02/16/2001
I	000570	49,431.39	02/09/2001
I	000554	12,078.51	02/02/2001
I	000528	19,754.86	01/26/2001
I	000524	84,496.88	01/19/2001
I	000510	19,211.96	01/12/2001
I	000498	53,635.03	01/05/2001
I	000474	15,714.16	12/29/2000
I	000470	27,941.35	12/22/2000

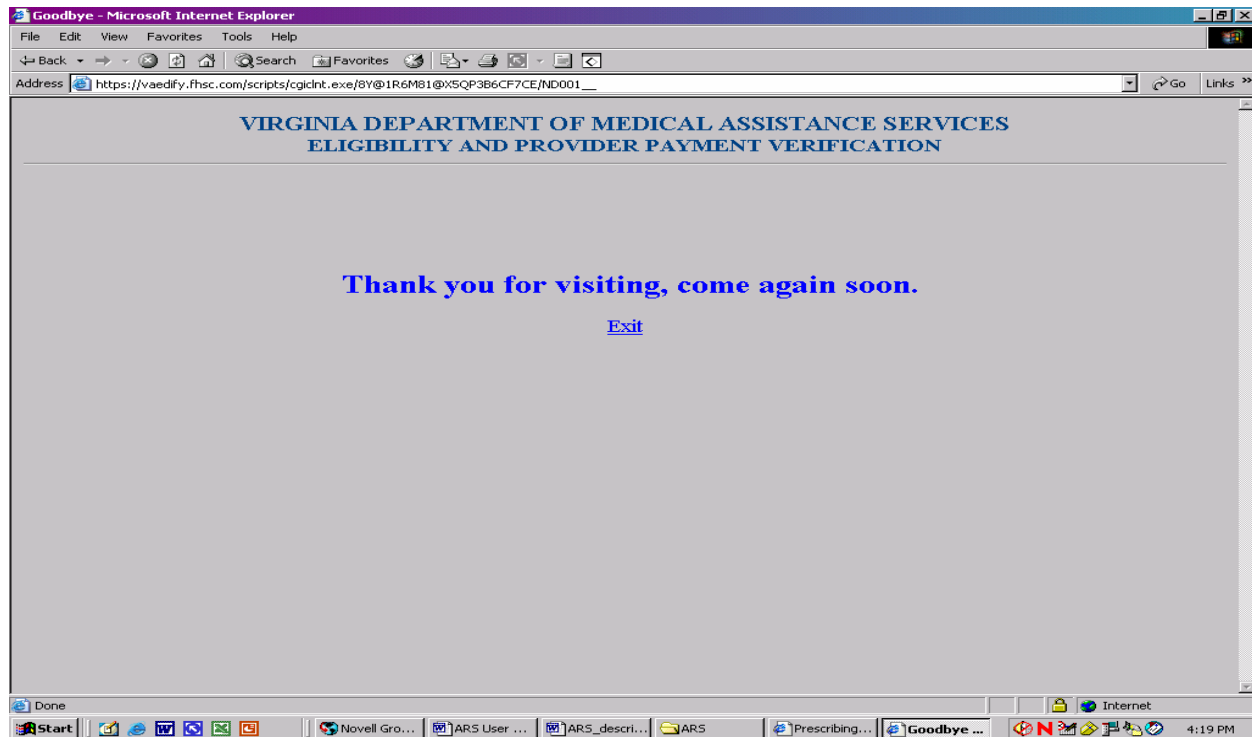
Menu Exit

 **NOTE:** For field definitions, hold the cursor over a field for a few seconds and a brief description will appear. This description states the type of information that is required for that field (e.g. alphabetical, numeric) and the total number of characters that can be entered. When entering data into a field, an alpha/numeric character appears. This is the HIPAA field name and will not affect the information that is being submitted. Ignore this character.

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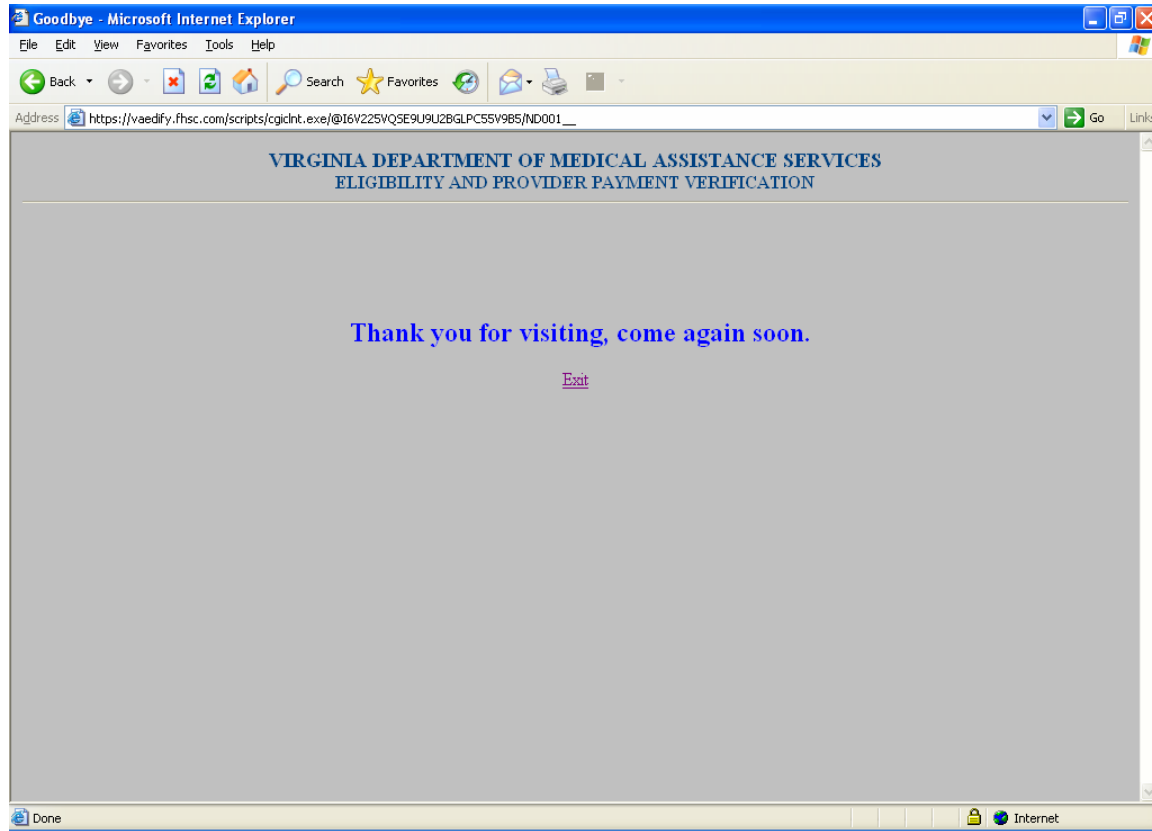
Exit Option

When “Exit” is selected from any screen within ARS, the following message will appear:



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If “Exit” is selected again, the following message will appear and you will be logged out of ARS:



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FAQ (FREQUENTLY ASKED QUESTIONS)

Registration Questions

Q. Why do I have to register for access to the online Eligibility and Provider Payment Verification?

A. The information that you are accessing is required to be secured under HIPAA regulations. The registration process allows verification that you as a provider are authorized to view this information.

Q. Once I register, how will I be contacted?

A. You will receive a letter from First Health Services (FHS) that will include your Personal Identification Number (PIN). The PIN number will allow you access to the User Administration Console (UAC) tool so you can continue the registration process to be able to access the ARS. You should receive the PIN letter within 5-7 days. The letter will be sent to the servicing provider address.

Q. Who should I contact if I experience problems while enrolling?

A. Please contact the Web Support Unit at 1-800-241-8726.

Q. Do I need a separate logon ID and password for each member of my staff?

A. Yes. The Delegated Administrator for your facility will assign each staff member a user ID and password to access the ARS system.

General Questions

Q. Is the system HIPAA compliant?

A. Yes, HIPAA-covered portions of the system, 270/271 Eligibility and 276/277 Claims Status are HIPAA compliant. The HIPAA standards have an exception called Direct Data

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Entry (DDE). HIPAA-covered portions of the system do “use applicable data content and data conditions of the standard.”

Q. I handle claims for several providers. After checking claim status for one provider, how can I check claim status for another?

A. To logon as another provider, click the “Exit” button until the Logged Out screen appears. Click on the “Login” button to logon as a different provider.

Q. Little strings of letters sometimes appear when the mouse is placed over data or a data element name. What are they?

A. They are abbreviated field names applicable to the HIPAA DDE standard. They do not have meaningful business usage and should be ignored.

Q. What are Constant Reference Designators and Descriptions (in the box at the bottom of the Eligibility and Claims Status screens)?

A. Each HIPAA-covered screen displays the constant elements defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are required in standard X12 transactions. They are not required to access the eligibility and provider verification system and should be ignored.

Eligibility Verification and Service Limits Questions

Q. What service dates can I use?

A. The Service From Date must be 1 month or less before the Service To Date. Both service from and to date must be entered. The From Date cannot be more than 1 year in the past. The To Date cannot be in the future.

Q. What if I don’t know the enrollee number?

A. You may key in any two of the following: SSN, Birth Date or Name.

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Q. What is the Provider's Control Number?

A. This is a tracking control number for internal purposes only. You are required to enter a value in this field. You might use your initials, the date, the medical record number, etc.

Q. How do I inquire on service limits?

A. When you fill out the Eligibility inquiry screen, pull down the service limits box by clicking on the down arrow to the right of "For Service Limits enter Service Type Code."

Q. I've just found that a given enrollee is eligible. Can I check another enrollee?

A. Yes, just use your browser's Back button to get back to the screen where you keyed in the first enrollee's number. Delete that number and key in the new.

Q. What is the meaning of the abbreviated Benefit Plan (Plan Coverage Desc) that is returned on the Eligibility DDE 271 screen?

A. Please use the matrix provided in Appendix A to clarify the meaning of the abbreviated Benefit Plan Short Name.

Claim Status Questions

Q. Does ARS show pended claims?

A. Yes.

Q. How does this compare with the HIPAA 835?

A. As a result of a claim, the 835 comes from First Health automatically in a batch of transactions. The 835 contains more information on claim status. This is not relevant to the inquiry on the web.

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Q. What's an ICN?

- A. It is the claim number assigned by First Health when the claim was received. The ICN was converted with the new system. The ICN that is referenced on your paper remittance advice will not work. Use the recipient number and date of service. Claims processed prior to July 03, 2003 are not accessible by ICN.

Q. What if I don't have the ICN?

- A. Key in
- Enrollee Number and Service Dates OR
 - Enrollee Number, Service Dates and Billing Provider.

Q. What dates can I use?

- A. The Service From Date must be 1 month or less before the Service To Date. Both service from and to date must be entered. The From Date cannot be more than 1 year in the past. The To Date cannot be in the future.

Q. What is the Cat Code and Code?

- A. The Health Care Claim Status Code (Code) and Category code (Cat Code) are converted from the claims disposition:

Disposition	Cat Code	Code
Paid	F1	65
Denied	F2	9
Adj/Void	F3	101
Pends	P2	421

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Prior Authorization (PA) Log Questions

Q. Can I authorize a procedure for a patient?

- A. No. The PA Log is a historical list of PA's. In other words, the PA Log shows the results of previous, successful authorizations.

Provider Login Questions

Q. What is the format of my Provider Login Userid?

- A. **To login using your Legacy Provider Identification Number (this login option can only be used until 05/22/2007):**

The Provider Login ID is an eleven-position number that consists of the provider number prefixed with "VA". If the provider number is only seven positions, then two (2) zeroes must be prefixed to the number between the "VA" and the seven position number. E.g. Provider number is "1234567" then the Provider's Login ID will be "VA001234567" for a total of 11 positions.

To login using your National Provider Identification Number (NPI):

The Provider Login ID is a ten-position number.

Q. How do I login as a different provider?

- A. Upon clicking the EXIT button within the Virginia Department of Medical Assistance Services – Eligibility and Provider Payment Verification System, A “Logged Out” page will display. Click on the “Login” button. The “Login” page will display and allow you to login again as a different provider.

Q. How do I stop the display of the Security Alert screen?

- A. Click the button that states, ‘Do Not Show This Screen Again’.

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Q. Who should I contact if I experience problems while trying to log in?

A. Please contact the Web Support Unit at 1-800-241-8726.

Q. When attempting to login, I received a screen with a message, ‘This Page Can Not Be Displayed.’ What does this mean?

A. There are several reasons for this message:

- You may not have the latest version of the browser. 128 bit is required. Follow your company procedures to have the newest version of the browser installed.
- Your internet connection may be down or disconnected.
- The FHSC network may be down. Contact the Web Support Unit (WSU) at 1-800-241-8726.

Q. Is there any cost for using the eligibility and provider payment verification system?

A. No, all costs are absorbed by CMS and the Commonwealth.

Q. I tried an incorrect password three times and now I am unable to log on. What should I do?

A. This is a security measure to avoid hacking. To have your password reset, please contact the Web Support Unit at 1-800-241-8726. You will be asked questions to verify your identity.

Q. I registered three days ago and have not heard anything. What is the next step?

A. The First Health Web Support Unit (WSU) has peak demands at times. Your PIN letter will arrive in 5-7 days with your personal identification number (PIN) so you can continue the registration process to be able to access the ARS. The PIN letter will be sent to the provider’s servicing address.

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Q. My password doesn't work.

- A. The password is case sensitive. If necessary, turn your Caps Lock key (on your keyboard) off. For example, "GetBetter" is different from "GETBETTER." If you are unable to resolve, then contact the Web Support Unit at 1-800-241-8726.

Q. I forgot my password.

- A. On the ARS log-on screen there is a "Forgot Your Password" question. Select the link and answer the Password Challenge question. You will be given a new password that must be changed the first time you attempt to use it.

Q. After I registered as a new provider, I was instructed to change my password when I logged in the very first time. How is this done?

- A. On the Login web page, enter your login userid and password that was assigned to you by the Delegated Administrator for your facility. Another page will display that will ask you to change your password. Enter your old password, your new password and, for verification purposes, your new password again. Click the "Submit" button.

Q. After I changed my password, the Login page was displayed again. What should I do?

- A. Key your login userid and new password and click the "Submit" button. You will be directed to the eligibility and provider payment verification system.

Q. What steps do I follow for accessing group provider information through UAC or ARS?

- A. Here are the steps to follow for accessing group provider information through UAC or ARS.

Step 1: UAC

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- The Delegated Administrator for the provider's office selects a group provider number to be sent a PIN letter.
- The PIN letter is generated and sent to the group provider's address on file.
- The group provider sends the PIN to the Delegated Administrator.
- The Delegated Administrator sets up the user ID and password when registering with the PIN received from the group provider.
- The Delegated Admin now has access to the entire group of providers. (No individual PINS from member providers needed.)
- The look-up functionality is available to the Delegated Administrator.

Step 2: UAC

- The Delegated Administrator sets up additional users in the UAC system with roles assigned to the Virginia ARS system and the group provider assigned to each user. (No additional PIN required).
- Users now have access to the entire group of providers through ARS. Only the group provider number will appear in the user provider list on UAC version 2.0.
- All look-up functionality is available for the users.

Step 3: UAC

- The Delegated Administrator adds individual member providers from the group one by one requesting a PIN for each.
- Each provider member must receive the PIN letter back so that each member can be added to the user provider lists.
- All individual provider members' provider numbers will appear in the user's provider listing on UAC version 2.0.
- The Delegated Administrator removes access to the group provider number and restricts user access to select providers as needed.

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APPENDIX A

Short Name – Benefit Plan (Plan Coverage Description)

Medicaid FFS – Medicaid Fee-For-Service

FAMIS Plus – Children Enrolled in Medicaid

XIX Central – Medicaid, Medallion II Central Area

XIX CMM Phys – Medicaid, Client Medical Management Physician

XIX CMM Rx – Medicaid, Client Medical Management Pharmacy

XIX CMM Tran – Medicaid, Client Medical Management Transportation

XIX Def. MCO – Medicaid, Default Mandatory Managed Care Organization

XIX FFS Emer – Medicaid, Fee-For-Service Emergency Services Only

XIX FFS Dial – Medicaid, Fee-For-Service Dialysis Services Only

XIX Halifax – Medicaid, Medallion II Halifax County

XIX ICF – Medicaid, Intermediate Care Facility

XIX LS Hosp – Medicaid, Long Stay Hospital

XIX M-3 CDPR – Medicaid, Medallion III Charlottesville, Danville, Pittsylvania Region

XIX M-3 LSWV – Medicaid Medallion III Lower Southwest Virginia Region

XIX M-3 MCO – Medicaid, Default Medallion III Managed Care Organization

XIX M-3 Nor VA – Medicaid, Medallion III Managed Care Organization Northern Virginia Area

XIX M-3 PCP – Medicaid, Medallion III MEDALLION PCP

XIX OS Prov – Medicaid, Out of State Provider

XIX PCP – Medicaid, MEDALLION Primary Care Provider (PCP)

XIX SNF – Medicaid, Skilled Nursing Facility

XIX Tidewtr – Medicaid, Medallion II Tidewater Area

XIX USWVA – Medicaid, Medallion II Upper Southwest Virginia Area

ASM ACR ASSM – ACR, Adult Care Residence Assessments

ASM NH LVL 1 – Assessments Nursing Home Level 1

ASM NH LVL 2 – Assessments Nursing Home Level 2

AIDS Waiver – AIDS Waiver

Aged Waiver – Elderly and Disabled Waiver

CDPAS Waiver – Consumer Directed Program Waiver

Fmly Pln Wvr – Family Planning Waiver

HIV Premium – HIV Premium

HIPP Premium – Health Insurance Premium Payment

HIDP – Health Insurance Demonstration Program

Hospice – Hospice Program

IFDSS Waiver – IFDSS Waiver

Intensive AL – Intensive Assisted Living

Med Co & Ded – Medicare Coinsurance & Deductibles

Med Premium – Medicare Premium

MR Waiver – Mental Retardation Waiver

Pre-PACE – Pre Program of All Inclusive Care for the Elderly

PACE – Program of All Inclusive Care for the Elderly

Prt Med Prem – Partial Medicare Premium

Reg Assist L – Regular Assisted Living

Regular AL – Regular Assisted Living

SLH – State and Local Hospitalization

TDO – Temporary Detention Order

Vent Waiver – Technology Assisted Waiver

FAMIS CMM Py – FAMIS, Client Medical Management Physician

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FAMIS CMM Rx – FAMIS, Client Medical Management Pharmacy

FAMIS Centra – FAMIS, Medallion II Central Virginia Region

FAMIS-CDPR – FAMIS, Medallion II Charlottesville, Danville, Pittsylvania Region

FAMIS FFS – FAMIS, Fee-For-Service

FAMIS-Half. – FAMIS, Medallion II Halifax County

FAMIS HIPPP – FAMIS, HIPPP Premium Payments

FAMIS ICF – FAMIS, Intermediate Care Facility

FAMIS LS Hos – FAMIS, Long Stay Hospital

FAMIS-LSWV – FAMIS, Medallion II Lower Southwest Virginia

FAMIS-MCO – FAMIS, Default Mandatory Managed Care Organization

FAMIS M3 MCO – FAMIS, Default Medallion III Managed Care Organization

FAMIS NorVA – FAMIS, Medallion II Northern Virginia Region

FAMIS OS Prv – FAMIS, Out of State Provider

FAMIS PCP – FAMIS, MEDALLION PCP

FAMIS Reg AL – FAMIS, Regular Assisted Living

FAMIS SNF – FAMIS, Skilled Nursing Facility

FAMIS Tr – FAMIS, Transportation

FAMIS Tidewr – FAMIS, Medallion II Tidewater Region

FAMIS-USWV – FAMIS, Medallion II Upper Southwest Virginia

Claim Status Category Code/Code

Disposition	Category Code	Default Status Code
Paid	F1	65
Denied	F2	9
Adj/Void	F3	101
Pends	P2	421

Default Status Codes are used only when a specific code is unavailable. The HIPAA 276/277 Implementation Guide can be obtained free of charge at <http://www.wpc-edi.com/products/publications>. The “Health Care Claim Status Category Codes and the Health Care Claim Status Codes” can also be obtained free of charge at <http://www.wpc-edi.com/products/codelists/alertservice>.

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GLOSSARY

ARS: Automated Response System

Benefit Plan: Plan coverage description (See Appendix A for a complete list of plans and there abbreviations.)

Carrier Name: Name of the TPL carrier

Claim Payment Amount: Actual amount paid by DMAS

Constant Reference Descriptor and Descriptions: Standard constant fields as defined by the HIPAA 270/271 and 276/277 Implementation Guides. These fields are typically HIPAA required fields, with a constant value unrelated to the Virginia MMIS application.

Health Care Claim Status (Cat Code): The category code under which the status falls (See Appendix A for a complete list of Claims Status Category Codes.)

Health Care Claim Status (Code): The code under which the status falls (See Appendix A for a complete list of Claims Status Codes.)

ICN (Payor Claim Control Number): The claim identifier assigned by DMAS

Line Item Charge Amount: Actual amount charged by provider for a given service

Line Item Provider Payment Amount: Actual amount paid by DMAS for a given service

Originating Company Number: A HIPAA required field; the intent is for systems that pass transactions multiple companies and multiple systems. It does not apply to this application. The provider number used at logon populates this field.

Payer's Control Number: A HIPAA required trace code; the user must enter a value that is then returned on the response screen. The system does nothing else with the value.

PIN: Personal Identification Number

PIN Letter: After registering to use the UAC tool the user will receive a letter. A personal identification number will be on this letter to use when completing registration.

Procedure Code (Service ID Code): The standard HIPAA codes; up to seven characters

Provider's Control Number: A tracking control number for internal purposes only; it is a required field. It can be a patient account number, a date and time, or any other alpha/numeric code chosen by the provider to track this inquiry.

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Remittance Date: The date the payment was made

Total Claim Charge Amount: Actual amount charged by provider

User Administration Console (UAC): A tool that will allow the provider to manage their own ARS access for one or more users.

Verification Number: A number returned by the MMIS that confirms the provider received a confirmation for enrollee eligibility; the provider may use it as an official reference number in the future.